Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com

A group benefits plan insured by Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, that may be administered by your employer. For more details, please refer to your employer.

GROUP INSURANCE - CONTRACT ADMINISTRATION

APPLICATION FOR ENROLMENT

ONA DENTAL PLAN FOR EARLY RETIREES
(AGES 60-64) CONTRACT NO. 542300

A - IDENTIFICATION

Please print.

Last name | First name

Address - No., street, apt. | City | Province | Postal code

Telephone number ( ) | E-mail address | Date of birth YYYY MM DD | Sex ☐ M ☐ F | Language ☐ E ☐ F

Retirement date YYYY MM DD | Last employer | Former contract number

B - DENTAL CARE BENEFIT

All the benefits offered in the policy are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein.

If you select family coverage, please complete section C below.

☐ Individual coverage (without dependents) ☐ Family coverage (with dependents)

C - IDENTIFICATION OF DEPENDENTS

Please complete this section if you selected a family coverage.

If you have more than 2 dependent children, please use another form no. 08039E or complete form no. 00291E.

SPOUSE

Last name | First name | Date of birth YYYY MM DD | Sex ☐ M ☐ F

☐ Married YYYY MM DD
☐ Common-law spouse - Start date of cohabitation:

- Was a child born of this union? ☐ No ☐ Yes - Provide details below.

Other insurance
☐ No
☐ Yes - specify to the right

Covered care or benefit
☐ Medical care [1]
☐ Paramedical care [1]
☐ Dental care

Coverage
☐ Individual ☐ Family
☐ Single-parent ☐ Couple

If your spouse is also insured by Desjardins Insurance*
Group no.:
Certificate no.:

DEPENDENT CHILDREN

1 Last name | First name | Date of birth YYYY MM DD | Sex ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2] YYYY MM DD YYYY MM DD

☐ Child aged 18 or older [3] and full-time student - please specify: Period: From To

Name of educational institution :

2 Last name | First name | Date of birth YYYY MM DD | Sex ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2] YYYY MM DD YYYY MM DD

☐ Child aged 18 or older [3] and full-time student - please specify: Period: From To

Name of educational institution :

- **Note 1 : Care included in Extended health care benefit.**
- **Note 2 : Please complete form no. 09296E and return it to the address shown on the form.**
- **Note 3 : Refer to your policy for eligible age.**

*** Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DSF).**

D - PERSONAL PRE-AUTHORIZED DEBITS

Please fill out form No. 09239E - Application for enrolment - Personal pre-authorized debits form, and include it with your application.

E - DECLARATION

I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the policy are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read and received a copy of the Personal Information Management section at the back of this form.

Signature of retiree: **Date:**

FOR INSURER USE ONLY

Please return the original to Desjardins Insurance and keep a copy for your file.

Documents sent on: YYYY MM DD

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PRINT NEW REQUEST

PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. I authorize Desjardins Insurance, its agents and service providers to collect, use and disclose information about me, my spouse or my dependents to any person or organization including the pharmacies, health care practitioners, institutions, investigative agencies or insurers for the purposes of underwriting, administration, optimal health management, auditing and paying claims.

You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address:

Privacy Officer
Desjardins Insurance
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.